

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 7, 8, 11, 12, 13, 14 & 15 File G262 5/16/60 3wk											
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN		a. STATE		b. COUNTY	
Charles		MARYLAND						Maryland		Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Newburg								Newburg			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Newburg											
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
WILLIAM						BAKER		April		12 1960	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		unknown 1917 43		yrs. Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
				Maryland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
George Barbara		Agnes Baker									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT							
No.				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Arteriosclerotic heart disease									
420.0		DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)									
		DUE TO									
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
19											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/13/60	
EXAMINER'S NAME (Type)		W. Bradley King, Jr., M.D.		Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)					
Burial		4-16-60		St Marys		New Port, Md					
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
W. H. Baran		1722 1/2 St		DATE APR 18 '60		Arthur L. House					

0138

(11)

4000

(1)

*Handwritten notes at the bottom of the page, including "The end of the world" and "The end of the world" repeated.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

4480

CERTIFICATE OF DEATH

64432  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles, Pomonkey</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Charles County</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>Elnora</u> First <u>Lurenia Barnett</u> Middle <u>Lucenia</u> Last			4. DATE OF DEATH <u>April 2nd</u> 19 <u>60</u> Month <u>April</u> Day <u>2nd</u> Year <u>1960</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/1899</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John Jones</u>			14. MOTHER'S MAIDEN NAME <u>Nellie Johnson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>214-32-9316</u>		
17. INFORMANT <u>Bertha J. Ward</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROSCLEROSIS</u> <u>332X</u> DUE TO <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>CEREBROTHROMBOSIS</u> (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>JUN 15</u> , 19 <u>57</u> , to <u>APR 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>APR 2</u> , 19 <u>60</u> , and that death occurred at <u>8:40 A</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Paul Chen</u>			ADDRESS (Street, city or town, state) <u>Accokeek, Md.</u> DATE SIGNED <u>APR 2-60</u>		
PHYSICIAN'S NAME (Type) <u>PAUL CHEN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stymont</u>		22d. LOCATION (City, town, or county) (State) <u>Charles County Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Better</u>			ADDRESS <u>1203 Walter St</u>		
24a. REC'D BY REGISTRAR <u>APR 6 '60</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>		



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VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64433  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis Edward Bean</b>		4. DATE OF DEATH Month Day Year <b>April 19 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1901</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Charles Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Bean</b>		14. MOTHER'S MAIDEN NAME <b>Mary Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Gloza Bean</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <b>4-22-'60</b>	
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/23/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>La Plata, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archart</i> <b>Archart Funeral Home, Inc. - La Plata, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 27 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>

MEDICAL CERTIFICATION





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G262 5/9/60 iwk

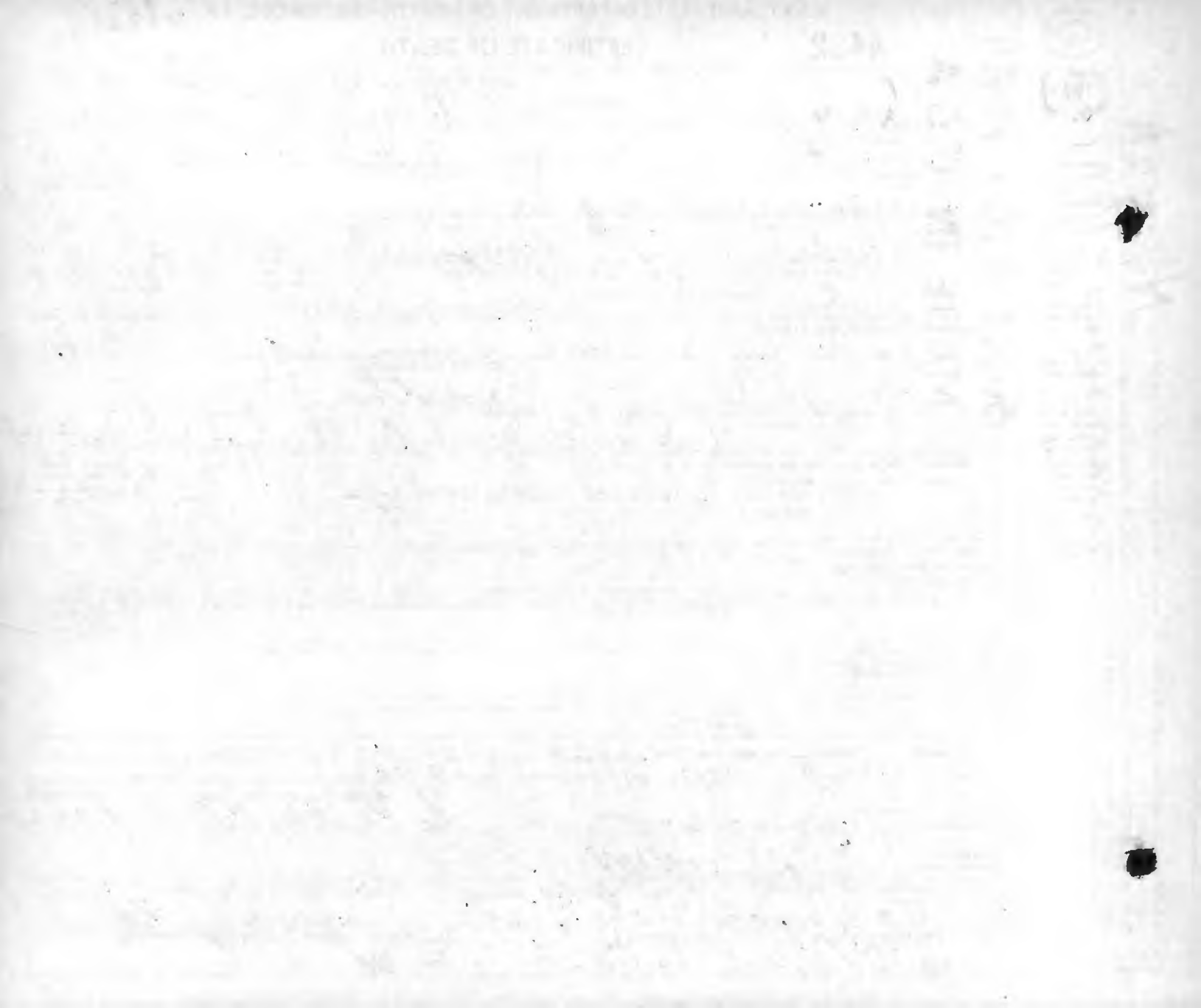
64434

4482

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Point (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Mem. Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Madeline L. Chesley</u>		4. DATE OF DEATH <u>APRIL 27 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1915</u>
9. AGE (In years last birthday) <u>44 1/4</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Danvers, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Till</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Donley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>M. James A. Chesley - Rock Point, Md.</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4-25</u> 19 <u>60</u> to <u>4-27</u> 19 <u>60</u> that I last saw the deceased alive on <u>4-27</u> 19 <u>60</u> , and that death occurred at <u>12:30 P.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>La Plata, Md.</u>	
DATE SIGNED <u>4-29-60</u>			
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/30/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>	22d. LOCATION (City, town, or county) <u>Danvers, Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Funeral Home, Inc.</u>		ADDRESS <u>La Plata, Md.</u>	
24a. REC'D BY REGISTRAR <u>La Plata, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. K...</u>	
DATE, <u>4 '60</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4483

# CERTIFICATE OF DEATH

Reg. Dist. No.

64435

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dentsville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>S.</u> Last <u>Cooksey</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 7, 1909</u>	
9. AGE (in years last birthday) yrs. <u>50</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James B. Cooksey</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Chrismond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-34-8772</u>		17. INFORMANT <u>W. Elmer Cooksey, Dentsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 MINS.</u> <u>2 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>April 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 2</u> , 19 <u>60</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Warren Jarboe</u> M.D.				DATE SIGNED <u>4-3-60</u>			
PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Newport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH  
 CERTIFICATE OF DEATH

John  
 Smith

Maryland  
 Potomac

Oct 11

Harry  
 M  
 Farmer  
 James A. Cooksey  
 Mary E. Christman  
 280-3-4222 R. E. Cooksey, Potomac Md

*[Faint, mostly illegible text in the middle section of the form]*

John  
 M. E. Cooksey  
 Mary E. Christman  
 280-3-4222 R. E. Cooksey, Potomac Md





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4485 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Doncaster</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Physicians Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>B</u> Last <u>Gilroy</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-1878</u>
9. AGE (In years and birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Bostain</u>	
14. MOTHER'S MAIDEN NAME <u>Josephine Dodi</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Albert Gilroy - Son - Route #1 Box 10, Newjersey, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 4 <u>0-1</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertensive Arteriosclerotic Heart Disease - old</u> DUE TO <u>Hypertensive Arteriosclerotic Heart Disease - old</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>50 min.</u> <u>50 min.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> <u>None</u>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Spontaneous onset at home</u>		20c. TIME OF INJURY Month, Day, Year <u>11:00 a.m. 4-26-1960</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Doncaster, Charles, Md</u>		20g. (County) <u>Charles</u>	
20h. (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>V.B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		4-27-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/29/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Laverne Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Piggah, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc. La Plata, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 '60</u>	
ADDRESS <u>Archart Funeral Home, Inc. La Plata, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
4486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64488									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville, Maryland</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Robert</u> Last <u>HILL</u>					4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 9, 1902</u>		9. AGE (in years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John S. Hill</u>					14. MOTHER'S MAIDEN NAME <u>Hattie Bird</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>1920-1921</u>		17. INFORMANT <u>Mrs. Lillie D. Hill - Hughesville, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> DUE TO <u>Right Pneumothorax</u> <u>5 min</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Stab wound right chest</u> <u>5 min.</u> (c) <u>Stab wound right chest</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stabbed during barroom argument</u>							
20c. TIME OF INJURY Hour <u>5:10 P.M.</u> Month, Day, Year <u>4-18 1960</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bar</u>		20f. (City or town) <u>Hughesville, Charles, Md.</u>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>V.B. Dettor</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Truett</u>			22d. LOCATION (City, town, or county) (State) <u>Bluefield, West Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archibald Funeral Home, Inc. - La Plata, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

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4487 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Jeff. Davis</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phys. Men. Hosp.</i>		d. STREET ADDRESS <i>Piscataway Rd</i>	
3. NAME OF DECEASED (Type or print) <i>TILBERT WILLIAM JOHNSON</i>		4. DATE OF DEATH <i>4 15 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-24-37</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Govt</i>		11. BIRTHPLACE (State or foreign country) <i>Charles Co., Md</i>	
13. FATHER'S NAME <i>Arthur W. Johnson</i>		14. MOTHER'S MAIDEN NAME <i>M. S. Dyson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>216-34-0971</i>	
17. INFORMANT <i>Ann R. Johnson, Clinton, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>819X</i> DUE TO <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Multiple fractures of arm</i> DUE TO (c) <i>auto accident</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Driver of car which left road and hit guardrail</i>	
20c. TIME OF INJURY <i>11</i> Hour <i>pm</i> Month, Day, Year <i>4-9-60</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) <i>Clinton</i> (County) <i>Jeff. Davis</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. J. EDELEN</i>		DATE SIGNED <i>4-18-60</i>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-19-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Pomonkey, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huntt Funeral Home</i>		24a. REC'D BY REGISTRAR <i>Waldorf, Md</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

8/17

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1.55 10M

Item 20 Film 261 4-29-60 and

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

Item 25 Film 5202 5/4/00 iwk

64441

## 4488 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Charles</b>		MARYLAND		STATE <b>Hawaii</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Indian Head</b>		LENGTH OF STAY (In this place) <b>1 month</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Pearl City</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Disp. Naval Propellant Plant</b>				STREET ADDRESS (If rural give location) <b>973 Franklin Ave</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Edmund Leroy JORDAN</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>April 13 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>9-16-26</b>	
9. AGE last birthday <b>33</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Diver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>		11. BIRTHPLACE (State or foreign country) <b>Providence R. I.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herbert C. JORDAN</b>				14. MOTHER'S MAIDEN NAME <b>Betrix Marion (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Yes 1943 - 1960</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Official U.S. Navy Records, NPP Ind Hd Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Asphyxiation due to smoke</b>				INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <b>3rd degree burns, left leg and thigh.</b>			
TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				(C)			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>Barracks</b>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>Indian Head Charles Md.</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>April 13 1960 0421M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>While on duty, he was struck in the head by a live fire extinguisher which smothered, as he was trying to extinguish it.</b>			
22. I hereby certify that I attended the deceased from <b>0419 4-13, 1960</b> , to <b>0421 4-13, 1960</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>0421M</b> , from the causes and on the date stated above.							
SIGNATURE <b>W. E. SILL JR. LT MC USN</b>				ADDRESS (Street, city, town, state) <b>NPP Ind Hd Md.</b>		DATE SIGNED <b>4-13-60</b>	
For: <b>E. J. EDELEN Charles County Coroner</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>4-19-60</b>		NAME OF CEMETERY OR CREMATORY <b>Highland Mem. Cemetery</b>		LOCATION (City, town, or county) (State) <b>Johnson, Rhode Island</b>	
24. REC'D BY REGISTRAR DATE <b>APR 18 1960</b>		REGISTRAR'S SIGNATURE <b>Charles E. Evans</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bailey-Shipp Funeral Home 417 Plainfield St. Providence, R.I.</b>			





may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4489

CERTIFICATE OF DEATH

64441

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X La Plata</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Piv ions Memorial Hospital</b>				d. STREET ADDRESS <b>Lawhorn Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>VIVIE KENDRICK LANGLEY</b>				4. DATE OF DEATH Month Day Year <b>April 9 19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 7, 1901</b>		9. AGE (In years last birthday) <b>58</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drycleaning; Busing Charles Co., I. d.</b>		11. BIRTHPLACE (State or foreign country) <b>J.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>J.S.A.</b>	
13. FATHER'S NAME <b>Peter W. Kendrick</b>				14. MOTHER'S MAIDEN NAME <b>Isobell C. Ry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-26-6675</b>		INFORMANT <b>Francis N. Langley - La Plata, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolism</b> <b>1927</b> DUE TO (b) <b>Metastatic Malignant Melanoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 MINS.</b> <b>18 MOS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 19 58</b> , to <b>April 9 19 60</b> that I last saw the deceased alive on <b>April 9 19 60</b> , and that death occurred at <b>2:59 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. PARRAN JARBOE</b> M.D.				ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>4-9-60</b>			
PHYSICIAN'S NAME (Type) <b>J. PARRAN JARBOE M.D.</b>				<b>La Plata, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Scored Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>La Plata, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Funeral Home, Inc. - La Plata, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE APR 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

MEDICAL CERTIFICATION

1909

4490

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Bryantown.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial Hospital</u>		1. d STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Amy</u> First <u>T.</u> Middle <u>MUDD</u> Last		4. DATE OF DEATH <u>APRIL</u> Month <u>2</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Bryantown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry A. Turner</u>		14. MOTHER'S MAIDEN NAME <u>Amelia R. Jameson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>De Sales Mudd, La Plata, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 421 DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Squamous cell carcinoma penis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>4 years.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> 1955, to <u>2 April</u> 1960, that I last saw the deceased alive on <u>2 April</u> 1960, and that death occurred at <u>9:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D.		ADDRESS (Street, city or town, state) <u>La Plata, Maryland.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY.</u>		DATE SIGNED <u>2 April 60</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-4-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>APR 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

Henry A. Turner  
No. 10  
De 29th  
America  
Baptist

29th Nov 1892  
Henry A. Turner

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4491

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64443

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA</u> b. COUNTY <u>DICKENS</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWBURN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLESS HILLS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>421 W. K. Shaw Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ETHEL</u> Last <u>PERREA</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES CLEMENT</u>	
14. MOTHER'S MAIDEN NAME <u>CSSC</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>WIFE - PERREA</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-28-60</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		DATE SIGNED <u>4-28-60</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	22d. LOCATION (City, town, or county) (State) <u>Kingstowne</u> <u>Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard E. Edele</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4492

## CERTIFICATE OF DEATH

64444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>		c. LENGTH OF STAY IN 1b <b>50-Drs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Irving Place</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Hubert Posey</b>		4. DATE OF DEATH Month Day Year <b>4-20-60</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W-NS</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-6-1887</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Henry Posey</b>		14. MOTHER'S MAIDEN NAME <b>Susan Julia Posey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>Unknown</b>	
17. INFORMANT <b>Richard Polley-Indian Head Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-Sclerosis</b> DUE TO <b>Senility</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Indefinite</b> <b>Indefinite</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-50</b> , 19____, to <b>4-20-60</b> , 19____, that I last saw the deceased alive on <b>4-20-60</b> , 19____, and that death occurred at <b>9-1</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Indian Head Md</b> <b>4-21-60</b>			
ACTUAL SIGNATURE <b>James E. Andrews MD</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc. - La Pl...</b>		24b. REGISTRAR'S SIGNATURE <b>DATE APR 27 '60</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate must be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

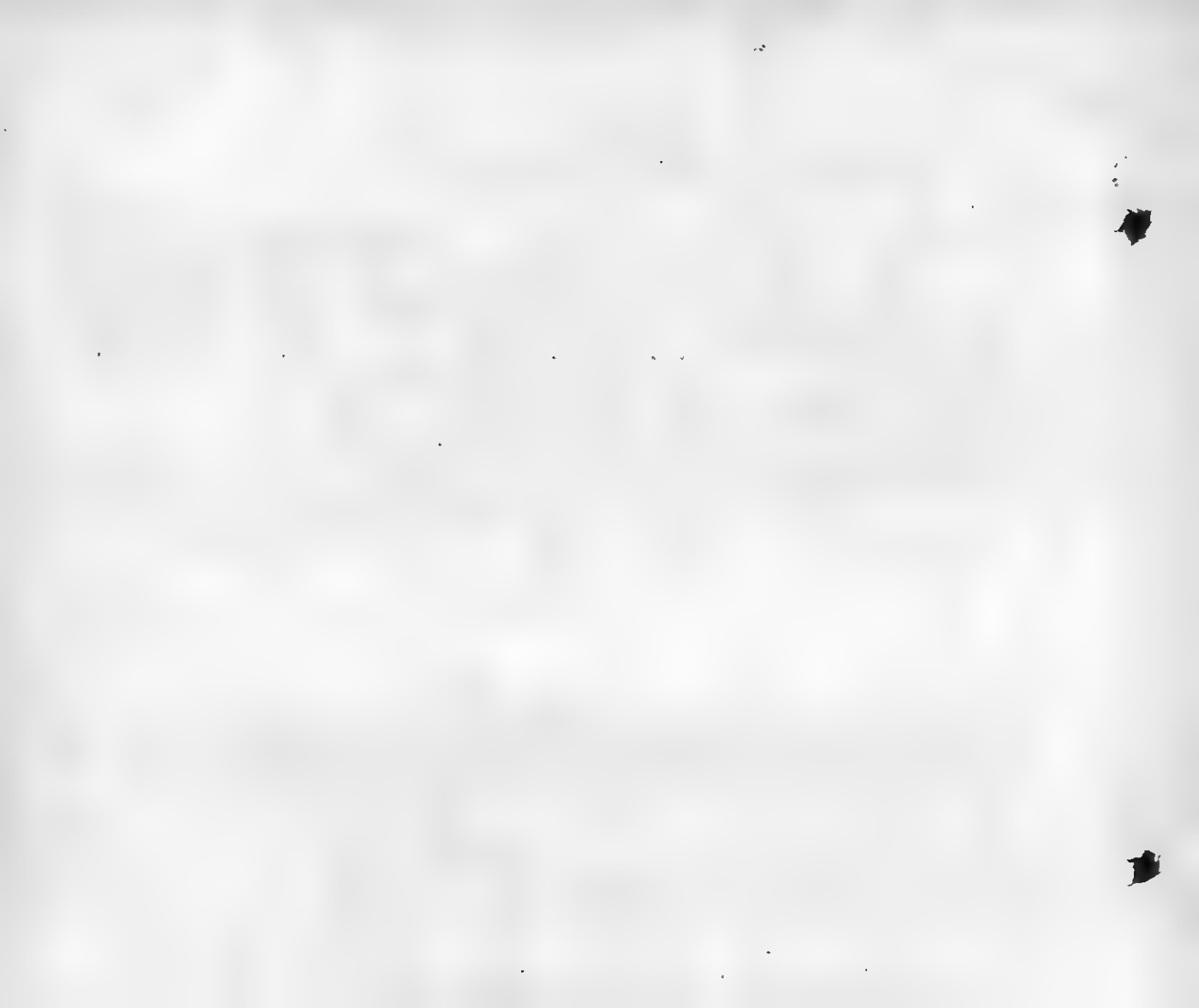
4493

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64445

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Pl ta</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nanjemoy</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Physicians Memorial Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Wilson Posey</b>				4. DATE OF DEATH Month Day Year <b>April 17 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1900</b>		9. AGE (in years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Powder Worker(Retired) U.S. Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Charles, Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Otis Posey</b>				14. MOTHER'S MAIDEN NAME <b>Magy Maddox</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Carroll R. Posey - Welcome, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Comminuted Fracture of Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Compound Fractures of Both Legs &amp; Arms</b> DUE TO (c) <b>Pedestrian hit by auto</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pedestrian who was hit by auto</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Pedestrian who was hit by auto</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>9 4-17 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>highway</b>		20f. (City or town) (County) (State) <b>Nanjemoy Ch. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. J. Edele</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>						DATE SIGNED <b>4-20-1960</b> <b>4-20-1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>4/20/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nanjemoy Baptist Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nanjemoy, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc. - La Pl ta, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE APR 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	



4494

CERTIFICATE OF DEATH

64446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Welcome</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Lee</b> Last <b>Proctor</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1960</b>
9 AGE (In years last birthday) <b>—</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min <b>—</b>	IF UNDER 24 HRS Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Raymond Riley, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Joan Elizabeth Proctor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16 SOCIAL SECURITY NO. <b>—</b>	
INFORMANT <b>Mother</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> <b>760.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Breech delivery with Brain Damage</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>31 H. 25 M.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no accident</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Breech delivery - difficult</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9:10</b> <b>3-30-60</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>La Plata, Charles, Md.</b>	
21. I certify that I attended the deceased from <b>3-30-1960</b> to <b>4-1-1960</b> , that I last saw the deceased alive on <b>3-31-1960</b> , and that death occurred at <b>4:35 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V.B. DETTOR</b>		ADDRESS (Street, city or town, state) <b>Box 397</b>	
PHYSICIAN'S NAME (Type) <b>V. B. DETTOR</b>		DATE SIGNED <b>4-1-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hill Top, Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Funeral Home - La Plata, Md.</b>		24. REC'D BY REGISTRAR <b>APR 5 '60</b>	
ADDRESS <b>La Plata, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)  
SM 9/35

4495

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata, Md.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>HOWARD</u> First <u>HOWARD</u> Middle <u>HOWARD</u> Last <u>HOWARD</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1930</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u> Hours <u>13</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11c. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>		11d. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel H. Rubey</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-13-60</u>	
17. INFORMANT <u>r. Samuel M. Rubey - Brother - Waldorf, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>CARDIAC CIRCULATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. Art. Deleterious</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-13-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-13-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Church Cemetery (Diney) Waldorf, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arrest Funeral Home, Inc. - La Plata, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 27 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4496

CERTIFICATE OF DEATH

4448  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie E. Scott</b>				4. DATE OF DEATH Month Day Year <b>April 21 1960 19</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10 1905</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Mundell</b>				14. MOTHER'S MAIDEN NAME <b>Louise Whalen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Agnes M. Babes 1704 M. St. N.E. Washington, D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>4-25-60</b> <b>Cardio Vascular Disease ?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-20-60</b> , to <b>4-21-60</b> , that I last saw the deceased alive on <b>4-21-60</b> , and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4-25-60</b> DATE SIGNED							
ACTUAL SIGNATURE <b>E. J. EDELLEN</b>				M.D.			
PHYSICIAN'S NAME (Type) <b>E. J. EDELLEN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-25-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Catherine's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mc Conchie, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Waldorf, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APP 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. KANA</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4407

## CERTIFICATE OF DEATH

Reg. Dist. No.

04449

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES Edward SMALLWOOD</u>		4. DATE OF DEATH <u>APRIL 6 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR: Months <u>8</u> Days <u>1</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Odd Jobs</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Edward Smallwood Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Addie Middleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	
17. INFORMANT <u>William Smallwood, Newburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>			
420.0 DUE TO (b) <u>Auricular Fibrillation</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Atherosclerotic Heart Disease</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>no injury</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>NEWBURG, CHARLES, MD.</u> (County) (State)	
21. I certify that I attended the deceased from <u>FEB.</u> 19 <u>60</u> , to <u>APRIL 6 1960</u> that I last saw the deceased alive on <u>APRIL 5 1960</u> , and that death occurred at <u>7:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. B. Aelter</u> M.D.		ADDRESS (Street, city or town, state) <u>Box 397</u> DATE SIGNED <u>4-8-60</u>	
PHYSICIAN'S NAME (Type) <u>J. B. DETTOR</u>		<u>La Plata, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-9-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>	22d. LOCATION (City, town, or county) (State) <u>Issue, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Woburn, Md.</u>		24. REC'D BY REGISTRAR DATE <u>APR 12 '60</u> REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Faulkner</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Effie Lane SWANN</b>		4. DATE OF DEATH <b>APRIL 7 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Lane</b>		14. MOTHER'S MAIDEN NAME <b>Ella ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Dorothy Freeman, Chapel Hill, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>420.0</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Anteriosclerotic Heart Disease</b> (b) <b>Anteriosclerotic Heart Disease</b> (c) <b>Anteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>24 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility and malnutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No injury</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. <b>No injury</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>La Plata, Charles, Md.</b> (County) (State)	
21. I certify that I attended the deceased from <b>FEB 24, 1960</b> to <b>APRIL 7, 1960</b> , that I last saw the deceased alive on <b>APRIL 7, 1960</b> , and that death occurred at <b>6:21 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V B DETTOR</b> M.D.		ADDRESS (Street, city or town, state) <b>Box 397</b> DATE SIGNED <b>4-8-60</b>	
PHYSICIAN'S NAME (Type) <b>V B DETTOR</b>		<b>La Plata, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-11-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Ignatius</b>	22d. LOCATION (City, town, or county) (State) <b>Bel Alton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The HUNTT Funeral Home, Waldorf, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>APR 12 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Hunt</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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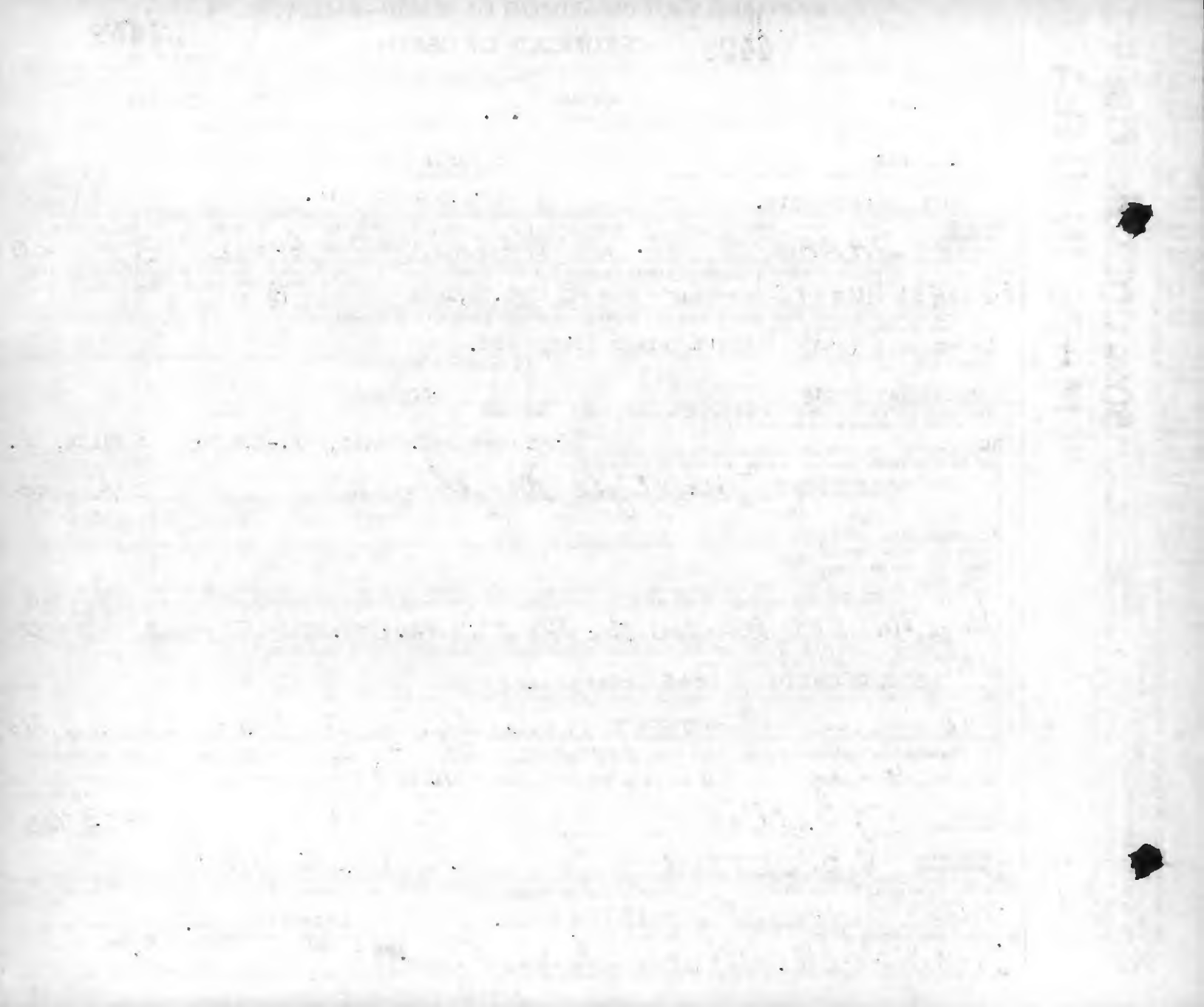
## CERTIFICATE OF DEATH

64452  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Port Tabacco Hgts.</b>		d. STREET ADDRESS <b>Port Tabacco Hgts.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SARA</b> First <b>V.</b> Middle <b>WAGNER</b> Last		4. DATE OF DEATH <b>APRIL 3 1960</b> Month <b>3</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker (rtd) &amp; Gov't Worker (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Emanuel Dougherty</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Joseph B. Hicks, Sr.-Box 585, La Plata, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>203X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Arteriosclerotic Heart Disease &amp; Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>	
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no accident</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>	
20c. TIME OF INJURY Month, Day, Year <b>no injury</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Exposed at home</b>		20f. (City or town) <b>La Plata, Charles, Md.</b> (County) (State)	
21. I certify that I attended the deceased from <b>11-20 1959</b> to <b>4-2 1960</b> , that I lost s/he the deceased on <b>4-2 1960</b> , and that death occurred at <b>10:55 A.M.</b> from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>V.B. DETTOR</b> M.D.		ADDRESS (Street, city or town, state) <b>Box 397 La Plata, Md.</b> DATE SIGNED <b>4-3-60</b>	
PHYSICIAN'S NAME (Type) <b>V.B. DETTOR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner &amp; Sons - Balt 17 Md</b>		24a. REC'D BY REGISTRAR <b>4 60</b> DATE <b>4 60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #3-FilmG261-4/26/60-mmb

4500

CERTIFICATE OF DEATH

Reg. Dist. No.

64454

1. PLACE OF DEATH a. COUNTY <b>Charles</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laplate Md</b>				c. LENGTH OF STAY IN 1b <b>15-Minutes</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hosp, Laplate Md.</b>				d. STREET ADDRESS <b>Bryand Road Md</b>			
3. NAME OF DECEASED (Type or print) <b>Harry Lester Wooster</b>				4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W-US</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-6-1884</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Franklin Wooster</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Middaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>417-36-6355</b>		17. INFORMANT <b>Russell Speak- Grandson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Senility</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10-Hours</b> <b>Indefinite</b> <b>Indefinite</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1-1-50</b> , 19____, to <b>4-16-60</b> , 19____, that I last saw the deceased alive on <b>4-16-60</b> , 19____, and that death occurred at <b>5:12 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <i>[Signature]</i> MD. <b>Indian Head Md</b>				DATE SIGNED <b>4-17-60</b>			
PHYSICIAN'S NAME (Type) <b>James E. Andrews</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-19-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chicamuxen</b>		22d. LOCATION (City, town, or county) (State) <b>Chicamuxen, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Waldorf, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 19 60</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

*Journal of Management Inquiry* 18(6)

1406 *Journal of Interpersonal Violence* 26(8)

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